



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is **only a summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For in-network providers : \$350 /individual or \$700 /family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. In-network preventive care & immunizations, office visits, emergency room visits, and urgent care facility visits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For in-network providers \$1,600 /individual or \$3,200 /family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.myCigna.com , www.CignaMedicalGroup.com or call 1-800-Cigna24 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	Yes.	This plan will pay some or all of the costs to see a contracted specialist for covered services but only if you have a referral before you see the specialist .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay /visit Deductible does not apply	Not covered	None
	Specialist visit	CCN Specialist: \$45 copay /visit** Non-CCN Specialist: \$70 copay /visit** ** Deductible does not apply	Not covered	None
	Preventive care / screening / immunization	No charge/visit** No charge/screening** No charge/immunizations** ** Deductible does not apply	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge Deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$100 copay per type of scan/day	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at OptumRx 866-312-1597 www.optumrx.com	Generic drugs (Tier 1)	Not covered	Not covered	Prescription benefits provided by OptumRx, the OptumRx Co-Insurance Plan.
	Preferred brand drugs (Tier 2)	Not covered	Not covered	Prescription benefits provided by OptumRx, the OptumRx Co-Insurance Plan.
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	Prescription benefits provided by OptumRx, the OptumRx Co-Insurance Plan.
	Specialty drugs (Tier 4)	Not covered	Not covered	Prescription benefits provided by OptumRx, the OptumRx Co-Insurance Plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$125 copay /visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	\$200 copay /visit Deductible does not apply	\$200 copay /visit	Per visit copay is waived if admitted
	Emergency medical transportation	No charge	No charge	None
	Urgent care	\$75 copay /visit Deductible does not apply	\$75 copay /visit	Per visit copay is waived if admitted
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay /admission	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services Magellan Health Services 888-213-5125 www.magellanhealth.com/member	Outpatient services	Not covered	Not covered	Benefits provided by Magellan Health Services
	Inpatient services	Not covered	Not covered	Benefits provided by Magellan Health Services
If you are pregnant	Office visits	No charge	Not covered	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$250 copay /admission	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	16 hour maximum per day
	Rehabilitation services	\$70 copay /visit Deductible does not apply Chiropractic Care: \$30 copay/visit, Deductible does not apply	Not covered	Coverage is limited to annual max of: 60 days for Rehabilitation services ; 36 days for Cardiac rehab services; 24 days for Chiropractic care services
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	No charge	Not covered	Coverage is limited to 90 days annual max.
	Durable medical equipment	\$75 copay /item Deductible does not apply	Not covered	None
	Hospice services	No charge/inpatient services and No charge/outpatient services	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)			
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (Adult) • Dental care (Children) • Eye care (Children) • Habilitation services 	<ul style="list-style-type: none"> • Long-term care • Mental/Behavioral health inpatient and outpatient services • Non-emergency care when traveling outside the U.S. • Prescription drugs 	<ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (Adult) • Routine foot care • Substance use disorder inpatient and outpatient services • Weight loss programs 	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Bariatric surgery • Hearing aids 	<ul style="list-style-type: none"> • Chiropractic care (24 days) 	<ul style="list-style-type: none"> • Infertility treatment

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-244-6224.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and excluded services under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$350
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$350
Copayments	\$300
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$30

The total Peg would pay is	\$680
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Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$350
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$6,200

The total Joe would pay is	\$6,400
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$350
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is	\$400
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.